STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING 01 B. WING	08/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN46107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/05/11 Facility Number: 000029 Provider Number: 155072 AIM Number: 100275200 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Beech Grove Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping	K0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.This provider respectfully requests that the Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after 9-4-11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	rooms. The facility has a capacity of 132 and had a census of 124 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/10/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 1 kitchen rolling fire doors in the opening between the kitchen and the Main Dining room is held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect all residents, staff and visitors	K0021	**K021 NFPA 101 Life Safety Code Standard** It is the policy of this facility for any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure to be held open by devices arranged to automatically close upon activation of fire alarm system, smoke detection system or	09/04/2011

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	in the vicinity of the Main Dining room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:15 a.m. to 1:10 p.m. on 08/05/11, the kitchen adjoins the Main Dining room and a serving window from the adjoining kitchen has a rolling fire door equipped with a fusible link. The Main Dining room was not separated from the corridor because the entry to the Main Dining room is not separated from the corridor by positive latching doors. An inspection tag attached to the rolling fire door frame indicated the last annual inspection of the rolling fire door occurred in November 2010. The building fire alarm system was activated at 12:50 p.m. and the serving window rolling fire door did not close upon activation of the fire alarm system. Based on interview at the time of observation, the Maintenance Supervisor stated the serving window rolling fire door should have closed upon activation of the fire alarm system and acknowledged the Main Dining room is not separated from the corridor by any entry door provided with positive latching hardware and the serving window rolling fire door did not close automatically upon activation of the fire alarm system.		automatic sprinkler system, if installed. **What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?** · There were no residents cited in regard to this regulation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Facility contracted with an outside vendor to install mechanism to ensure roll down doors in the dining room will be interconnected with the fire alarm system to automatically close upon activation of the system. · The kitchen rolling fire doors have anticipated work order completion of compliance date but is dependent on contractors schedule. Quotes obtained on 8-23-11. Fire doors will be observed to ensure compliance during scheduled fire drills, once door is repaired.**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	3.1-19(b)		Fire doors will be observed using "Fire Drill report form" during quarterly fire drills on each shift for the timeframe of six months to ensure compliance, once door is repaired. Audits will be reviewed by the CQI committee.	
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 2 kitchen doors with self closing devices are equipped with a positive latching mechanism to securely latch each door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity the Main Dining Room. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:15 a.m. to 1:10 p.m. on 08/05/11, the two entry doors from the Main Dining Room into the kitchen are each equipped with a self closing device	K0029	**K029 NFPA 101 Life Safety Code Standard** It is the policy of this facility for smoke barriers to be constructed to provide at least a one half hour fire resistance rating and doors with self closing devices are equipped with a positive latching mechanism to securely latch each door into the door frame.**What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?** · There were no residents cited in regard to this regulation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All Residents, staff and visitors have the potential to be	09/04/2011

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	but each door is not equipped with a positive latching mechanism to securely latch the door into the door frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledge each kitchen door is not equipped with a positive latching mechanism. 3.1-19(b)		affected by the alleged deficient practice. **What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · Both of the two entry doors from the main dining room into the kitchen have been equipped with a latching mechanism that securely latches the door into the door frame. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · An environmental CQI tool will be utilized weekly x 4 and monthly thereafter for timeframe of six months to ensure self closing doors latch upon shutting. The audits will be reviewed by the CQI committee.	
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct fire drills in 1 of 4 calendar quarters during the third shift. This deficient practice could affect all residents, staff and visitors.	K0050	**K050 NFPA 101 Life Safety Code Standard** It is the policy of this facility for fire drills to be held at unexpected times under varying conditions, at least quarterly on each shift. **What**	09/04/2011

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	Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 11:15 a.m. on 08/05/11, there is no written record of a fire drill being conducted on the third shift during April, May or June 2011. Based on interview at the time of record review, the Maintenance Director stated one fire drill was conducted on the first shift in April 2011 and two fire drills were conducted on the second shift in May and June 2011 instead of one fire drill for each shift and the Maintenance Director acknowledged there is no written record of a fire drill being conducted on the third shift for one of four calendar quarters. 3.1-19(b) 3.1-51(c)		**corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?** · There were no residents cited in regard to this regulation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** · A fire drill will be conducted on third shift prior to 9-4-11.Maintenance Director will be reeducated on need for fire drills on each shift.· The Maintenance Director will be responsible for ensuring that that fire drills are held at unexpected times under various conditions, at least quarterly on each shift and turn in attendance record of the drill to the Executive director or designee upon time of completion.**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Fire drill report CQI tool will be utilized weekly x 4 and monthly thereafter for timeframe	

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			of six months to monitor compliance with fire drills being conducted at least quarterly on each shift. The audits will be reviewed by the CQI committee.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the "Emergency Generator-Weekly Exercise/Monthly Load Test" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 11:15 a.m. on 08/05/11, the emergency generator was run on a monthly basis for at least thirty minutes each month for the period of 07/06/10 through 07/06/11 but the	K0144	**K0144 NFPA 101 Life Safety Code Standard** It is the policy of this facility for generators to be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. **What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice?** · There were no residents cited in regard to this regulation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **What systematic measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The settings on the generator are currently within the guidelines of 10 second transfer time and will be documented as such. Maintenance Director will inservice the maintenance assistants prior to 9-4-11 on how	09/04/2011

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	"Transfer Time" listed in the monthly logs utilized by the facility recorded the time to transfer power from the main source to the emergency generator as "100". Based on interview at the time of record review, the Maintenance Supervisor stated the transfer times recorded in the monthly log did not indicate the transfer time was within 10 seconds and acknowledged the transfer time to transfer power to the emergency generator was not recorded as being within 10 seconds for each month. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:		to properly record the percent of load capacity in the generator maintenance log. Generator tests are now being performed and documented showing that the emergency generator is being load tested at not less than 30% of the EPS. Natural gas provider letter has been changed and is now signed by the "General Manager of Engineering." This was obtained on 8-5-11. The generator will be provided with battery powered emergency task lighting prior to compliance date.**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · An environmental CQI tool will be utilized weekly x 4 and monthly thereafter for the timeframe of six months to monitor compliance of the Emergency Generator/Load Test documentation. The battery powered emergency lights will be monitored by maintenance on a monthly basis ongoing to ensure compliance. Audits will be reviewed by the CQI committee.	

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	a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the "Emergency Generator-Weekly Exercise/Monthly Load Test" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 11:15 a.m. on 08/05/11, the emergency generator ran on a monthly basis for at least thirty minutes each month for the period of 07/06/10 through 07/06/11 but the minimum exhaust gas temperature was not recorded and the percentage of load capacity was recorded as 208 to 210. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the percentage of load capacity recorded as 208 to 210 did not indicate each monthly load test for the generator was at not less than 30 percent of the EPS nameplate rating.			

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	3.1-19(b) 3. Based on record review and interview, the facility failed to ensure the reliable source documentation for the off site fuel source for 1 of 1 emergency generators was signed by a person with the technical expertise to make the reliable source claim. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all clients, staff and visitors.			

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	CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all occupants as well as staff and visitors. Findings include: Based on review of Citizens Gas' natural gas supplier letter dated 05/08/08 with the Maintenance Supervisor during record review from 9:15 a.m. to 11:15 a.m. on 08/05/11, the natural gas provider letter was signed by the "Commercial Sales Consultant". Based on interview at the time of record review, the Maintenance Supervisor stated the fuel source for the emergency generator was natural gas and acknowledged the natural gas provider letter was not signed by a technical person			

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	from the natural gas provider. 3.1-19(b) 4. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around 1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:15 a.m. to 1:10 p.m. on 08/05/11, the emergency generator set was located outside the facility within a fenced courtyard and was not provided with battery powered emergency task lighting. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the generator set was not provided with battery powered emergency task lighting.			

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